STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S , VELVA, North Dakota, 58790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident and a complaint was completed on December 17, 2025. During the report and complaint investigation the facility was found out of compliance with regulatory requirements. An extended survey was completed January 6, 2026.	F0000		01/09/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F0580	On 1/8/2026 reviewed Resident #3 falls since 11/27/2025 with Primary Physician. Resident #3 chart reviewed by Primary Physician and made the following changes: added vitamin b-12 injection, stopped spironolactone and gabapentin and changed the Tylenol order. Any resident who has a fall has the potential to be affected. All resident falls in the last 30 days were reviewed to ensure proper notification occurred if there was a suspected head injury. All licensed nurses educated on responsibilities of notifying the on call physician by phone if there is a suspected head injury on 12/24/25. Process Change: Morning meeting template updated to include each business day IDT team reviewed resident fall information to ensure proper notification occurred. Facility Director of Nursing Services or designee will conduct audits on 100% of falls weekly for four weeks, 50% of new incidents per month for the next two months, then random selection of five residents per quarter for the next three quarters Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: January 13th, 2026.	01/13/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

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F0580 SS = D	Continued from page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician for 1 of 1 sampled resident (Resident #3) reviewed for falls. Failure to notify the resident’s physician of changes in condition promptly may prevent the physician from altering treatment/care. Findings include: Review of the facility policy titled "Fall Prevention and Management" occurred on 12/17/25. This policy, revised 10/14/25, stated, ". . . For residents with suspected head injury, physicians should be notified by phone and not fax. . . ." Review of Resident #3's medical record occurred on 12/17/25. Diagnoses included Alzheimer’s disease, dementia, and repeated falls. A care plan review, dated 09/29/25, identified falls, and gait/balance problems. Review of Resident #3's progress notes identified the following: * 12/06/25 at 6:40 a.m., “Safety Event. . . Resident came up to the nursing station and stated, ‘I fell in my room and hit my head and I have another knot on the back of my head.’ She stated that 'He' helped her back	F0580		

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F0580 SS = D	Continued from page 2 to bed. Upon writer's assessment, resident was found to have a knot with bruising to the rt. [right] back of her head . . . Fax sent to Dr. [Doctor]. . ." * 12/06/25 at 2:07 p.m., "Communication/Visit with Physician. . . notified by email . . . All neuro's [neurological] and VS [vital signs] have been stable." * 12/09/25 at 3:06 p.m., "Communication/Visit with Physician . . . resident has had eight falls since 10-7-2025, six of them have been since 11-20-2025. . ." During an interview the afternoon of 12/17/25, an administrative staff member (#1) confirmed the facility failed to notify Resident #3's physician by phone regarding a head injury 12/06/25.	F0580		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F0657	Resident #2's care plan was updated to reflect her current functional ability on 12/17/25 Any resident has the potential to be affected by this practice. On 12/24/25 Administrator provided education to all staff on the need to keep residents care plans current with their care needs. Process change: At clinical meeting each business day, IDT Team will review care plan and update as indicated for any resident change in treatment plan. Director of Nursing Services or designee will conduct care plan audits on five residents weekly for four weeks, ten residents per month for the next two months, then ten residents per quarter for the next three quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: January 13th, 2026.	01/13/2026

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F0657 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 1 of 9 sampled residents (Resident #2). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan" occurred on 12/17/25. This policy, dated December 1, 2025, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, . . . needs. . . .The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. . . ." Review of Resident #2's care plan, revised 11/01/24, identified assistance of one staff member required for bed mobility, positioning up in bed, turning from side to side, oral care, dressing, and transfers between surfaces, and assistance of two staff members required to move from lying to sitting and sitting to lying positions. Resident #2's Minimum Data Set (MDS), dated 10/31/25, identified no impairment of the upper and lower extremity, independent with oral hygiene, dressing upper and lower body, bed mobility, sitting to standing, toilet transfers, and wheelchair mobility. The facility failed to update Resident #2's care plan for an improvement in physical mobility and ADL status. During an interview on 12/17/25 at 2:50 p.m. an administrative staff member (#1) confirmed facility staff failed to update Resident #2's care plan to reflect her current functional ability.	F0657		